The State Children's Health Insurance Program (SCHIP)
Final Regulation Summary -- HCFA 2006-F
Implementing the Balanced Budget Act of 1997
<<< Informational Transmittal #2-0101 >>>

The SCHIP final regulations are the result of the Department s careful consideration of more than 1,000 pages of public comments on the Notice of Proposed Rulemaking (NPRM) published in the *Federal Register* on November 8, 1999. The commenters included over 100 individuals, organizations, and States. The NPRM was based on policies outlined in two dozen "Dear State Health Official" letters, five sets of questions and answers; and a State plan application template. The final rules build on the NPRM, clarify the intent and interpretation of the title XXI statute and in some cases, the rules include modifications that reflect our additional experience with the program. This document provides a provision-by-provision summary of the final rule.

Subpart A - Introduction: State Plans for Child Health Insurance Programs and Outreach Strategies *(Applies to both Medicaid expansion and Separate child health programs)*

Section 457.1 - Program Description

- This provision gives a general description of the State Children s Health Insurance Program (SCHIP).

Section 457.2 - Basis and Scope of Subchapter D

- This provision describes the authority provided for in title XXI to set forth State plan requirements, standards, procedures and conditions for obtaining Federal financial participation (FFP) for providing coverage to targeted low-income children.

Section 457.10 - Definitions and Use of Terms

- This subsection provides the general definitions and terms used throughout these regulations. Terms that apply only to a specific subpart are defined at the beginning of that subpart. Key definitions include:

    - *American Indian/Alaska Native*
    - *Applicant*
    - *Child health assistance*
    - *Cost Sharing*
    - *Emergency medical condition/Emergency services*
    - *Medicaid applicable income level*
    - *Optional targeted low-income child*

- *Premium assistance program*
- *Targeted low-income child*

Section 457.30 - Basis, Scope and Applicability of Subpart A

- This provision gives the basis for the provisions governing the administration of SCHIP, the general requirements for a State plan under the program, a description of the process for review of a State plan or plan amendment, and notes the applicability to all States receiving FFP to provide child health assistance under title XXI.

Section 457.40 - State Program Administration

- This provision requires States to implement the program in accordance with the approved State plan, approved plan amendments, and statutory and regulatory requirements. This provision specifies that the State plan or plan amendment must be signed by the Governor or designee and must identify the State officials, by position or title, who are responsible for program administration and financial oversight.

Section 457.50 - State Plan

- This provision describes the State plan, which contains all of the information necessary for HCFA to determine whether the plan can be approved to serve as a basis for FFP in the State program.

Section 457.60 - Amendments

- This provision describes a State's right to amend its State plan, in whole or in part, at any time. When a plan amendment has a significant impact on the approved budget, the State must also submit an amended 1-year budget (where a 3-year budget was previously required).

This provision also sets forth the circumstances under which a State must submit a State plan amendment including as a result of changes in Federal or State law, regulations or policy that affect the following program elements:

- Eligibility standards, enrollment caps and disenrollment policies;
- Substitution prevention procedures, including exceptions to waiting periods;
- Type of health benefits coverage;
- Addition or deletion of specific categories of benefits;
- Delivery system approach;
- Cost sharing;
- Screen and enroll and other Medicaid coordination procedures; and
- Procedures for review of adverse eligibility, enrollment or health services decisions.

Finally, the provision requires States to submit amendments to indicate changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

Section 457.65 – Effective Date and Duration of State Plans and Plan Amendments.

- This provision specifies that the State plan or plan amendment takes effect on the day specified in the plan or plan amendment. It also describes the length of time that an amendment may remain in effect prior to being submitted to HCFA. It specifies the rules applying to amendments that eliminate or restrict eligibility or benefits, or modify cost sharing, enrollment procedures, or the source of State funding. It allows the State plan to continue in effect unless and until the State adopts a new plan by obtaining approval of a plan amendment or the Secretary finds substantial non-compliance of the plan with SCHIP requirements.

Section 457.70 - Program Options

- This provision specifies that a State may obtain health benefits coverage through a separate child health program, a Medicaid expansion program or a combination program. It also specifies the program requirements in effect for each of these options.

Medicaid expansion programs must meet the requirements of --

- Subpart A, State plan requirements and Outreach strategies
- Subpart B, General Administration (Financial)
- Subpart F, Allotments and Payments to States
- Subpart G, Strategic planning, Reporting and Evaluation; and
- Subpart J, Allowable Waivers

Separate child health programs must meet all of the requirements of these final rules.

Section 457.80 - Current State Child Health Insurance Coverage and Coordination

- This provision requires a State to describe the procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs and sources of health benefits coverage for children; the extent and manner in which children have creditable health coverage; the current State efforts to provide or obtain creditable health coverage for children; the procedures to accomplish coordination between SCHIP and other health insurance programs; and the procedures to ensure that children are appropriately enrolled in the program for which they are eligible.

  Note: *We have also modified section 435.636 of the Medicaid regulations to require parallel coordination by the Medicaid agency with SCHIP programs.*

Section 457.90 - Outreach

- This provision specifies that a State must describe in its State plan the procedures to implement outreach strategies intended to inform families of the availability of the programs and to assist them in enrolling if eligible. The provision also provides examples of outreach strategies such as public education and awareness campaigns, enrollment simplification activities, and application assistance strategies such as working with community-based organizations and in collaboration with other programs to reach children.

Section 457.110 - Enrollment Assistance and Information Requirements

- This provision requires States to make accurate, easily understood, linguistically appropriate information available to potential applicants, applicants and enrollees and to provide assistance to families in making informed decisions about their health plans, professionals, and facilities. It requires States to make available to applicants and enrollees information on benefits, cost sharing, the names and locations of participating providers, circumstances under which enrollment caps or waiting lists may be instituted, and inform families about physician incentive

plans and the review process that is available to address adverse eligibility or health services decisions.

Section 457.120 - Public Involvement in Program Development

- This provision requires a State to describe the methods used to involve the public in the design and implementation of the program on an ongoing basis; and requires States to ensure interaction with Indian Tribes and organizations on the development and implementation of the program.

Section 457.125 - Provision of Child Health Assistance to American Indian and Alaska Native Children

- This provision requires a State to describe the procedures used to ensure the provision of child health assistance to American Indian and Alaska Native children. The State must also include an exemption from cost sharing for American Indian and Alaska Native children.

Section 457.130 - Civil Rights Assurance

- This provision requires a State to assure that it will comply under its State plan with all applicable civil rights requirements including the Civil Rights Act, the Americans with Disabilities Act, the Rehabilitation Act, the Age Discrimination Act, and relevant portions of the Code of Federal Regulations.

Section 457.135 - Assurance of Compliance with Other Provisions

- This provision requires a State to assure that it will comply under title XXI with certain provisions of titles XIX and XI of the Social Security Act.

Section 457.140 - Budget

- This provision requires a State to include with any State plan or plan amendment that has a significant impact on the approved budget an amended budget that describes the State's planned expenditures for a 1-year period (rather than the 3-year period that has been required previously). It also specifies that the budget must describe the planned use of funds, including –
  - The projected amount to be spent on health services;
  - Projected administrative costs;
  - Assumptions including cost per child and expected enrollment; and
  - Projected source of non-Federal plan expenditures, including cost sharing to be imposed on enrollees.

Section 457.150 - HCFA Review of State Plan Material

- This provision describes HCFA's authority to review and approve or disapprove State plans and plan amendments. It specifies that the Administrator will designate an official to receive the initial submission of a State plan or plan amendment and an individual to coordinate review for each State that submits a State plan or plan amendment.

Section 457.160 - Notice and Timing of HCFA Action on State Plan Material

- This provision specifies that the Administrator will provide written notification to the State regarding approval or disapproval of a State plan or plan amendment. In addition, it specifies the rules governing the 90-day review period for HCFA review and action on a State plan or plan amendment.

Section 457.170 - Withdrawal Process

- This provision explains that a State may withdraw its proposed State plan or plan amendment at any time during the review process by providing written notice to HCFA. It also explains that a State may request to withdraw an approved State plan at any time.

Subpart B - General Administration - Reviews and Audits; Withholding for Failure to Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments ***(Applies to both Medicaid expansion and Separate child health programs)***

Note: These provisions are technical modifications to HCFA-2114-F, which was published in the Federal Register on May 24, 2000.

Section 457.203 - Administrative and Judicial Review of Action on State Plan Material

- This provision identifies the actions a State may take if they are dissatisfied with the Administrator's action on State plan material, requires the Administrator to notify the State of the time and place of a hearing to be held for the purpose of reconsideration, defines hearing procedures, and explains the effects of a hearing decision.

Section 457.204 - Withholding of Payment for Failure to Comply with Federal Requirements

- This provision describes reasons for withholding of payment and the opportunity for corrective action. Payments will be withheld if the State found to be in substantial noncompliance with title XXI, however a State will have reasonable opportunity for correction. Corrective action is action taken by the State to ensure that the plan is administered consistent with applicable laws and regulations as well as to ameliorate past deficiencies in plan administration and to ensure that enrollees are treated equitably. When an enforcement action is taken by HCFA, the State will be required to submit evidence of corrective action within 30 days.

Section 457.208 - Judicial Review

- This provision sets forth the State's right to a judicial review, petition for review, and court action.

Subpart C -State Plan Requirements: Eligibility, Screening, Applications, and Enrollment *(Applies only to Separate child health programs)*

Section 457.300 - Basis, Scope, and Applicability

- This provision generally describes subpart C, which sets forth and interprets eligibility requirements pertaining to an SCHIP.

Section 457.301 -Definitions and Use of Terms

This provision describes the definitions and terms used for purposes of this subpart.

- A definition of a *joint application* has been added and the definition of *employment with a public agency* has been removed. In addition, the final rules modify the definition of *State health benefits plan* to exclude plans in which the State provides no contribution toward the cost of coverage and in which no State employees participate, or plans that provide coverage for a specific type of care, such as dental or vision care.

- As a result of the Medicare, Medicaid and SCHIP Benefits and Improvement Protection Act of 2000 (BIPA), which formally extended the authority for States to make presumptive eligibility determinations for children applying for SCHIP to separate child health programs, the final rules include definitions of the terms *qualified entity, period of presumptive eligibility and presumptive income standard* in this subsection. (See also section 457.355)

  - A *qualified entity* is an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children. This term specifically includes entities authorized to determine eligibility for Head Start, child care services under the Child Care and Development Block Grant of 1990, WIC, the Stewart B. McKinney Homeless Assistance Act, the U.S. Housing Assistance Act or the Native American Housing Assistance and Self Determination Act; and certain elementary and secondary schools including those operated by the Bureau of Indian Affairs. This term also includes other entities designated by the State, as approved by the Secretary of HHS.

  - A *period of presumptive eligibility* begins on the date on which a qualified entity determines that a child is presumptively eligible and ends on the earlier of the day action is taken on the application or not more than 60 days after the presumptive eligibility determination was made.

  - The *presumptive income standard* is the highest eligibility standard established by the State to determine eligibility for a child of the age of the child involved.

Section 457.305 -State Plan Provisions

- This provision sets forth the requirement that the State plan must include a description of the standards, consistent with sections 457.310 and 457.320, used to determine the eligibility of children for coverage under the State plan. It also requires States to describe their policies governing enrollment and disenrollment; screening and facilitating enrollment in Medicaid, if applicable; and instituting waiting lists and/or enrollment caps.

Section 457.310 -Targeted Low-Income Child

- This provision defines targeted low-income child and the standards for qualifying as such. The child must show that they --
  - Meet the financial need standard;
  - Have no other coverage and are not:
    -- eligible for coverage under a State health benefits plan;
    -- an inmate of a public institution;
    -- a patient in an institution for mental disease (IMD) at the time of initial application or any redetermination of eligibility.

Section 457.320 - Other Eligibility Standards

- This provision sets forth the eligibility standards that may and may not be used when determining eligibility for targeted low-income children under the State plan.

  - The State may adopt eligibility standards related to geographic areas served by the plan; age; income; resources; spend downs; disposition of resources; residency; disability status; other health coverage; and duration of eligibility.

  - A State may <u>not</u> cover children with higher family income over children with lower incomes; deny eligibility based on a preexisting medical condition; discriminate based on diagnosis; require the provision of a Social Security Number; exclude AI/AN children based on medical care provided by the Indian Health Service; or exclude individuals based on citizenship or nationality to the extent that the children are U.S. citizens, U.S. nationals, or qualified aliens.

  - A State may accept self-declaration of citizenship as long as the State has fair, effective and non-discriminatory procedures in place to ensure the integrity of the application process.

  - States may generally establish residency rules, except that a State may not impose a durational residency requirement.

- States may not impose a lifetime cap or other time limit on eligibility that is based on the length of time a child has received benefits under the program; and eligibility must be determined every 12 months.

Section 457.340 -Application for and Enrollment in a Separate Child Health Program

- This provision sets forth the application procedures that a State must follow when determining eligibility for targeted low-income children under a separate child health program, including:

  - States must inform applicants, in writing or orally as appropriate, of their rights and responsibilities as part of the application process and provide them an opportunity to apply without delay.

  - States must provide information about the eligibility requirements, their obligations under the program, and their right to review of enrollment matters.

  - States must promptly determine SCHIP eligibility, within a period not to exceed 45 calendar days, except in circumstances that are beyond the State's control. The State defines the date of application.

  - States must provide written notice of decisions concerning eligibility. In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the parent or caretaker to take any appropriate actions that may be required or allowed, so that coverage can continue without interruption.

Section 457.350 -Eligibility Screening and Facilitation of Medicaid Enrollment

Note: *To improve the understanding of the requirements for eligibility screening and facilitating of Medicaid enrollment, proposed section 457.350 -- Eligibility Screening -- and section 457.360 -- Facilitating Medicaid Enrollment -- have been combined into one section. (See also the related Medicaid requirements at section 431.636.)*

- This section sets forth the screening procedures States must follow to ensure that all applicants that are potentially eligible for Medicaid are identified and enrolled in Medicaid if found eligible. The provision also addresses the procedures States must follow for children found potentially ineligible for Medicaid.

  - States must screen for Medicaid eligibility under whatever Medicaid income category generally results in the broadest eligibility for children. Screening is not required for all Medicaid eligibility categories.

  - If a State applies a resource test in Medicaid, the State must conduct a resource screen in order to make a more complete assessment of a child's potential Medicaid eligibility prior to enrolling them in the separate program.

  - When children are identified as potentially Medicaid eligible, the States must establish procedures in coordination with the Medicaid agency to facilitate enrollment in Medicaid and avoid duplicative requests for information. The State must promptly transmit the application information to the Medicaid agency; inform families of their potential eligibility for Medicaid; and provide assistance completing the Medicaid application process.

  - If a child screened as likely to be eligible for Medicaid is later found ineligible for Medicaid, upon notification, the State determines eligibility for the separate program without requiring the family to complete a new application.

  - The State must ensure that children have been appropriately screened prior to placing a child on a waiting list or otherwise deferring action on the child's application for a separate child health program. In addition, families must be informed that the child may become eligible for Medicaid if circumstances change while the child is on a waiting list for a separate program.

  - The State may establish other effective and efficient procedures, in coordination with the Medicaid agency, to ensure that children who are screened as potentially eligible for Medicaid have the opportunity to apply for and enroll in Medicaid, if eligible, in a timely manner.

Section 457.353 – Monitoring and Evaluation of the Screening Process

- This provision requires States to monitor and evaluate the screen and enroll process to ensure that eligible children are appropriately enrolled in either Medicaid or SCHIP.

Section 457.355 – Presumptive Eligibility

Note: *This provision was added to these final rules as a result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).*

- This provision establishes that States may provide presumptive eligibility for children in the separate child health program pending a final determination of eligibility. In general, expenditures for coverage during a period of presumptive eligibility for the separate child health program will be eligible for enhanced matching funds.

Section 457.380 - Eligibility Verification

- This provision requires States to establish procedures to ensure the integrity of the eligibility determination process. The State may establish reasonable eligibility verification mechanisms to promote enrollment of eligible children.

Subpart D - Coverage and Benefits: General Provisions
(Applies only to Separate child health programs)

Section 457.401 - Basis, Scope and Applicability

- This provision generally describes subpart D, which sets forth and interprets requirements for health benefits coverage and other child health assistance under a separate child health program.

Section 457.402 - Definition of Child Health Assistance

- This provision defines *child health assistance* as defined in the statute and lists the services available for payment under a separate child health program.

Section 457.410 - Health Benefits Coverage Options

- This provision lists the four health benefits coverage options from which a State may choose to design its child health assistance program. It also includes the statutory requirement that States must obtain coverage for well-baby and well-child services; age-appropriate immunizations; and emergency services.

Section 457.420 - Benchmark Health Benefits Coverage

- This provision defines benchmark coverage that must be provided to targeted low-income children as health benefits coverage that is substantially equal to the health benefits coverage in:

  - The Federal Employees Health Benefits Plan (FEHBP);
  - The State employee benefits plan; or
  - The health maintenance organization with the largest insured commercial non- Medicaid enrollment in the State.

Section 457.430 - Benchmark Equivalent Health Benefits Coverage

- This provision describes the requirements to which the State must adhere in designing a benchmark equivalent benefit package for its targeted low-income children:

  - The coverage must be actuarially equivalent to coverage under one of the benchmark packages described in section 457.420.
  - The coverage must include inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and may include other services.
  - If the benchmark package includes prescription drugs, mental health, vision or hearing services, then the value of the coverage for each of these services in the package offered by the State must equal at least 75 percent of the value of these services under the benchmark.

Section 457.431 - Actuarial Report for Benchmark-equivalent Coverage

- This provision describes the process for developing an actuarial analysis and comparing the actuarial value of coverage of the benchmark package to the State-designed benchmark-equivalent benefit package for its targeted low-income children.

- The State must submit to HCFA an actuarial report that specifies the benchmark coverage used for comparison and that was prepared by a member of the American Academy of Actuaries and uses a specific set of generally accepted, standardized actuarial principals in making the comparison. The report must include sufficient detail to enable HCFA to replicate the State's result.

Section 457.440 - Existing Comprehensive State-based Coverage

- This provision identifies the three existing comprehensive State-based programs (New York, Florida, and Pennsylvania) that were "grandfathered-in" as acceptable coverage programs according to the statute. The provision includes conditions under which States may modify the existing coverage programs for use in developing a SCHIP program.

Section 457.450 - Secretary-approved Coverage

- This provision describes ways a State may define Secretary-approved coverage for its separate child health program. Secretary-approved coverage may include:

  - The same benefits as are provided under the Medicaid State plan (a "Medicaid look-alike");
  - A comprehensive benefit package offered under an 1115 waiver that either offers the full EPSDT benefit or that has been extended to the entire Medicaid population in the State;
  - A benchmark plan plus any additional benefits ("Benchmark-plus"); or
  - Coverage that is substantially equivalent to the benchmark, demonstrated through a benefit-by-benefit comparison that each benefit meets or exceeds coverage under the benchmark.

Section 457.470 - Prohibited Coverage

- This provision explains that States are not required to provide health benefits coverage under the State plan for certain items or services for which payment is prohibited under title XXI, even if a benchmark plan includes coverage for that item or service.

Section 457.475 - Limitations on Coverage: Abortions

- This provision describes the conditions under which abortion services may be provided under title XXI and discusses the treatment of managed care entities providing this service under a separate contract.

Section 457.480 - Preexisting Condition Exclusions and Relation to Other Laws

- This provision describes the applicability of the preexisting condition exclusion and the parts of HIPAA, ERISA, the Mental Health Parity Act, and the Newborns and Mothers Health Protection Act that apply to SCHIP.

Section 457.490 - Delivery and Utilization Control Systems

- The State plan must include a description of proposed methods of delivery and utilization control systems to ensure that children receive care that is appropriate and medically necessary, consistent with the benefit package described in the approved State plan.

Section 457.495 - State Assurance of Access to Care and Procedures to Assure Quality and Appropriateness of Care

Note: *This section was previously located in Subpart G, Strategic Planning.*

- This provision requires that the State plan include a description of the methods a State will use to assure the quality and appropriateness of care and access to care; specifically, how the State will assure:

  - Access to well-baby, well-child and well-adolescent care and childhood and adolescent immunizations;
  - Access to covered services, including emergency services;
  - Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when necessary.

- Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after the request for services.

Subpart E - State Plan Requirements: Enrollee Financial Responsibilities
(Applies only to Separate child health programs)

Section 457.500 - Basis, Scope and Applicability

- This provision describes the statutory basis for the cost-sharing provisions for separate child health programs.

Section 457.505 - General State Plan Requirements

- This provision requires that the State plan specify**:**

  - The amount of cost sharing imposed;
  - The methods (including a description of the public schedule) the State uses to inform the public of the cost sharing amounts;
  - The protections for enrollees being disenrolled for failure to pay cost sharing;
  - When a State purchases family coverage or coverage through a premium assistance program -- the procedures used to ensure that enrollees are not charged cost sharing for well-baby/well-child care; that AI/AN children are not charged cost sharing, and that cost sharing charges do not exceed the 2.5 or 5 percent cap.
  - Procedures that primarily rely on a refund to the enrollee when the cap is exceeded are not acceptable.

Section 457.510 - Premiums, Enrollment fees, or Similar Fees: State Plan Requirements

- This provision discusses that the State plan must describe the amount of the premium, enrollment fee or similar fee, the time period for which it is imposed, the group(s) subject to the premium or fee, the consequences for failure to pay and disenrollment protections and the methodology to ensure that the family does not exceed the cumulative cost-sharing maximum.

Section 457.515 - Co-payments, Coinsurance, Deductibles, or Similar Cost Sharing Charges: State Plan Requirements

- This provision discusses what information the State plan must include regarding co-payments, coinsurance, deductibles, or similar cost sharing charges. The plan must include information on

the services, the amount, the group of enrollees subject to cost-sharing charges, consequences for enrollees who do not pay cost sharing and disenrollment protections, the methodology for ensuring that an enrollee does not pay cost sharing in excess of the cumulative cost-sharing maximums and an assurance that the family will not be held liable for cost sharing amounts, (beyond the amounts specified in the State plan), for emergency services provided out-of-network.

Section 457.520 - Cost Sharing for Well-baby and Well-child Care

- This provision requires that cost sharing not be imposed on enrollees for well-baby/well-child care services. The services considered to be well-baby/well-child care under this provision include at a minimum:

  - Healthy newborn physician visits;
  - Routine physical exams;
  - Laboratory tests associated with routine physical exams;
  - Immunizations and related office visits; and
  - Routine preventive and diagnostic dental services.

Section 457.525 - Public Schedule

- This provision requires States to publish and make available to enrollees (at both initial enrollment and at redetermination), applicants, participating providers and the general public a schedule of the cost-sharing charges that will be imposed on enrollees. The schedule must include:
  - Current cost-sharing charges;
  - Enrollee groups subject to the charges;
  - Cumulative cost-sharing maximums;
  - Payment mechanisms
  - Consequences for failure to pay cost sharing;

Section 457.530 - General Cost Sharing Protection for Lower Income Children

- This provision instructs States to not vary premiums, deductibles, coinsurance, co-payments or any other cost sharing based on family income that favors children from families with higher income over children from families with lower income.

Section 457.535 - Cost Sharing Protection to Ensure Enrollment of American Indians/Alaska Natives

- This provision notes that States may not impose cost sharing on children who are American Indians/Alaska Natives. States may permit self-declaration of membership in a Federally recognized tribe.

Section 457.540 - Cost Sharing Charges for Children in Families At or Below 150 Percent of the FPL

- This provision specifies the maximum allowable cost sharing amounts for children in families with income below 150 percent of the FPL.

  - The maximum co-payment amounts allowed on children at or below 100 percent of the FPL are based on the Medicaid nominal amounts contained in Medicaid regulations.
  - For children with incomes between 101 and 150 percent of the FPL, cost sharing is limited to amounts permitted in section 457.555.
  - The State may not impose more than one type of cost-sharing charge on a service.
  - The State may only impose one co-payment based on the total costs of services furnished during one office visit.

Section 457.555 - Maximum Allowable Cost Sharing Charges on Targeted Low-Income Children with Income from 101 to 150 Percent of the FPL

- This provision sets forth that the maximum co-payment levels allowed on children with family incomes between 101 and 150 percent of the FPL:

  - Co-payments may be between $1 and $5 based on the cost of services provided;
  - Copayments may be up to $5 in a managed care setting;
  - Coinsurance may not exceed 5 percent of the payment the State, directly or through a managed care contract, makes for the services; and
  - Deductibles may not exceed $3.00 per month per family deductible.
  - Maximum allowable charges for institutional services may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service system on the first day of care in the institution;
  - Charges for institutional emergency services may not exceed $5;
  - The State may charge up to $10 for non-emergency use of the emergency room; and
  - The standard co-payment amount for any service may be determined using the State's average or typical payment for that service.

Section 457.560 - Cumulative Cost Sharing Maximum

- This provision defines how States must compute cost-sharing amounts in calculating whether the family has met the cumulative cost-sharing maximum.

  - For children with family incomes at or below 150 percent of the FPL, all forms of cost sharing may not exceed 2.5 percent of total family income for a year.
  - In families above 150 percent of the FPL, all forms of cost sharing may not exceed 5 percent of total family income for a year.
  - States must inform the family in writing, and orally if appropriate, of their cumulative cost-sharing maximum at the time of enrollment as well as at renewal.

Section 457.570 - Disenrollment Protections

- This provision describes the procedures States must have in place regarding disenrollment for failure to pay cost sharing.

  - States must give enrollees a reasonable opportunity to pay past due cost-sharing amounts prior to disenrollment from SCHIP;
  - The disenrollment process must afford the enrollee an opportunity to show that the family's income has declined and take steps to change the child's status in the event that the enrollee qualifies for Medicaid or for a lower level of cost sharing under SCHIP.
  - The State must provide the enrollee with an opportunity for an impartial review of the decision to disenroll the child.

Subpart F - Financial Regulation: Allotments and Payments to States
(Applies to both Medicaid expansion and Separate child health programs)

HCFA 2114-F published in the Federal Register on May 24, 2000.

Subpart G - Strategic Planning, Reporting and Evaluation
(Applies to both Medicaid expansion and Separate child health programs)

Section 457.700 - Basis, Scope and Applicability

- This subpart describes the basis, scope and applicability of the subpart.

Section 457.710 - State Plan Requirements: Strategic Objectives and Performance Goals

- This provision requires that the State plan describe the strategic objectives, performance goals, and the performance measures the State has established. The plan must describe the State's:
  - Strategic objectives related to increasing the extent of coverage of low-income children;
  - Performance goal(s) related to each strategic objective; and
  - Performance measures using objective, independently verifiable means.
  - The strategic objectives must include a common core of national performance goals and measures (to be developed by the Secretary).

Section 457.720 - State Plan Requirement: State Assurance Regarding Data Collection, Records, and Reports

- This provision requires that the State plan provide an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary at the times and in the standardized format that the Secretary may require in order to monitor and evaluate State program administration and compliance and to compare the effectiveness of State plans under title XXI.

Section 457.740 - State Expenditures and Statistical Reports

- This provision discusses State expenditure and statistical reporting requirements:

  - States must report SCHIP expenditures and statistical data on a quarterly basis, with reports due to HCFA no later than 30 days after the end of each quarter of the Federal fiscal year.
  - States must report on the number of children under age 19 who are enrolled in separate child health programs, Medicaid-expansion programs and title XIX Medicaid programs by the following categories –
    -- Age;
    -- Gender, race and ethnicity;
    -- Service delivery system;
    -- Family income (poverty level determined by State-defined countable income and State-defined household size);
  - In addition, States annually must report an unduplicated count of children by these three categories for each preceding federal fiscal year.

Section 457.750 - Annual Report

- This provision discusses the type of information that States must provide in the annual report, due to HCFA on January 1st following the end of each Federal fiscal year. The State must provide an assessment of the operation of the State in the preceding federal fiscal year including:

  - The progress made in reducing the number of uncovered low-income children, meeting other strategic objectives and performance goals and information related to a core set of national performance goals and measures as prescribed by the Secretary;
  - Report on the effectiveness of the States policies for preventing substitution;
  - Identify successes and barriers in State plan design and implementation;
  - Progress in addressing issues the State plan committed to monitor and assess;
  - Provide an updated budget for a 3-year period;
  - Identify total State expenditures for family coverage (if applicable);
  - Collect and provide data regarding the primary language of SCHIP enrollees; and
  - Describe the State's current income standards and methodologies for the separate child health program, the Medicaid expansion program, and the title XIX Medicaid program, as applicable.
- In order to report on the progress made in reducing the number of uncovered low-income children, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children.

- A State may base the estimate on data from the March supplement to the Current Population Survey (CPS); use a statistically adjusted CPS; or use a State-specific survey or other appropriate data source.
- If the State elects not to use the CPS, it must submit a description of the methodology used to establish the baseline estimate.

The State must provide an annual estimate in the *changes* in the number of uninsured in the State using –

- The same methodology used in developing the initial baseline; or
- Another methodology based on new information that enables the State to establish a revised baseline.
- If a new methodology is established, the State must also provide annual estimates based either on the CPS or the initial baseline methodology.

Subpart H - Substitution of Coverage
(Applies only to Separate child health programs)

Section 457.800 - Basis, Scope and Applicability

- This provision describes subpart H, which sets forth and interprets requirements to prevent substitution of coverage under a separate child health program.

Section 457.805 - State Plan Requirement: Procedures to Address Substitution Under Group Health Plans

- This provision requires States in indicate in their State plan their procedures to ensure that health benefits coverage provided under the State plan will not substitute for coverage under a group health plan.

Section 457.810 - Premium Assistance Programs: Required Protections Against Substitution

- This provision describes the requirements for preventing substitution in States operating a premium assistance program, including:

- A minimum period of *6 months of uninsurance* (not to exceed 12 months);
  - States may permit reasonable exceptions to this requirement –
    -- Involuntary loss of coverage due to employer termination of coverage for all employees and dependents;
    -- Economic hardship;
    -- Change to employment that does not offer dependent coverage; or
    -- Other reasons approved as part of the State plan.
  - The waiting period requirement does not apply to children who have received coverage through Medicaid under section 1906 of the Act.
  - The Secretary retains the authority to modify the 6-month waiting period requirement.

- The State's program must be *cost-effective* -- the State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children.

- Employees eligible for coverage must apply for the full premium contribution available from the employer.

- States must evaluate the amount of substitution that occurs as a result of premium assistance programs and the effect of those programs on access to health coverage.

Subpart I - Program Integrity
(Applies only to Separate child health programs)

Section 457.900 - Basis, Scope and Applicability

- Subpart I, Program Integrity, finds its basis in both title XIX and title XI of the Social Security Act, which are referenced in title XXI

Section 457.902 - Definitions

- This provision describes the terms relevant to this subpart, including a definition of *Actuarially sound principles*, generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board; and a definition of *fee-for-service entity*, individuals or entities that furnish services under a fee-for-service program.

Section 457.910 - State Program Administration

- The State must provide safeguards necessary to ensure that eligibility is determined and services are provided in an appropriate and efficient manner that serves the best interests of the enrollees.

Section 457.915 - Fraud Detection and Investigation

- The State must have procedures in place to ensure program integrity and detection of fraud and abuse that do not infringe on legal rights of individuals involved and afford due process of law. States are also required to have procedures for coordination between the State program integrity unit, if the State elects to create one, and appropriate law enforcement officials.

Section 457.925 - Preliminary Investigation

- When a complaint or report is made, the State must conduct a preliminary investigation to determine whether further action is needed.

Section 457.930 - Full Investigation, Resolution and Reporting Requirements

- States must have procedures for investigation and resolution of instances related to fraud and abuse including but not limited to referring cases to the State program integrity unit (if applicable), conducting a full investigation and referring the case to the appropriate law enforcement officials.

Section 457.935 - Sanctions and Related Penalties

- Any provider that has been barred from participating in Medicare or Medicaid cannot become a SCHIP provider. All corresponding Medicaid disclosure requirements and the related penalties apply.

Section 457.940 - Procurement Standards

- This provision establishes payment limitations for SCHIP services by requiring that States:
  - Provide for free and open competition, to the extent possible, in the bidding of contracts for title XXI services; or
  - Use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness.
  - States may establish higher rates by justifying that such rates are necessary to ensure sufficient provider participation, provider access, or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.
  - The State must provide HCFA upon request, a description of the manner in which the payment rates were developed.

Section 457.945 - Certification for Contracts and Proposals

- All entities that contract with the State under a separate child health program must certify the integrity of all information specified by the State.

Section 457.950 - Contract and Payment Requirements Including Certification of Payment-related Information

- The State must ensure that contracts with managed care entities (MCEs) include enrollment and other required data and the MCE must attest to the accuracy and integrity of enrollee claims and payment data. In addition, the MCE must make that data available to the State upon request.

- States using fee-for-service must establish procedures to ensure the integrity of provider claims. Fee-for-service providers must provide the State with access to enrollee and payment data upon request by the State.

Section 457.955 - Conditions Necessary to Contract as a Managed Care Entity

- This provision requires States to ensure that MCEs have procedures in place to guard against fraud and abuse. States must enforce MCE compliance with all Federal and State standards and must have a mechanism for reporting fraud, abuse or violation of enrollment or payment requirements to HCFA or the OIG. States have authority to inspect or audit the MCE at any time, with reasonable cause.

Section 457.960 - Reporting Changes in Eligibility and Redetermining Eligibility

- This provision requires States to have procedures designed to ensure that enrollees make accurate reports in circumstances that may affect their eligibility and to conduct redeterminations upon a change in circumstances in a timely manner.

Section 457.965 – Documentation

- This provision requires States to include in each applicant s record, facts to substantiate eligibility determinations.

Section 457.980 - Verification of Enrollment and Provider Services Received

- States must have methodologies in place to verify the accuracy of provider billing and must maintain systems to verify enrollment where enhanced matching is received by the State.

Section 457.985 -- Integrity of Professional Advice to Enrollees

- This provision requires a State to ensure that its contractors comply with Medicare+Choice provisions describing:

  - Prohibitions on interference with health care professionals advice to enrollees and requires that professionals provide information about treatment in an appropriate manner.
  - It also enforces compliance with limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

Subpart J -- Allowable Waivers: General Provisions
(Applies to both Medicaid expansion and Separate child health programs)

Section 457.1000 - Basis, Scope, and Applicability

- This provision lays out the conditions under which States may obtain a waiver of the 10 percent cap on administrative expenditures and a waiver to provide coverage to entire families.

Section 457.1003 - HCFA Review of Waiver Request

- This provision indicates that HCFA will review waiver requests under this subpart using the same 90-day time frames used for State plan amendments

Section 457.1005 - Waiver for Cost-effective Coverage through a Community-Based Health Delivery System

- This provision describes the requirements a State must follow to exceed the 10 percent limitation on administrative costs in order to provide child health assistance to targeted low-income children under the state plan through the utilization of cost-effective community-based health care delivery systems.

    - Coverage must meet all the requirements of this part, especially the benefits and cost-sharing requirements; and
    - The cost of coverage, on an average per child basis, may not exceed the cost of coverage under the State plan.
    - An approved waiver remains in effect for no more than 3 years.

Section 457.1010 - Waiver for Purchase of Family Coverage

- This provision describes a waiver that allows the State to provide coverage to an entire family coverage in lieu of individual coverage. To receive payment for purchase of family coverage under the plan:

    - The State must establish that the cost of covering the family is cost effective, meaning it will cost no more than to cover the individual child;
    - The State must demonstrate that such coverage shall not substitute for other health insurance coverage.
    - The coverage for the family otherwise meets the requirements of this part.

Section 457.1015 - Cost Effectiveness

- This provision describes the waiver requirements for demonstrating cost effectiveness in determining whether to provide family coverage in lieu of individual coverage.

    - *Cost-effectiveness* means that the State's cost for purchasing family coverage is equal to or less than the State's cost of obtaining coverage for the eligible targeted low-income children involved.

- A State may demonstrate cost-effectiveness by comparing the cost of coverage for the family to the cost of covering the children only on a case-by-case or an aggregate basis.
- Cost-effectiveness must be assessed in the initial request for a waiver and then annually.
- For any State that chooses the aggregate cost method, if an annual cost-effectiveness assessment reveals that the proposal was not cost-effective, the State must assess cost-effectiveness on a case-by-case basis.
- The State must report on costs and enrollment related to family coverage in its annual report.

Subpart K -- Applicant and Enrollee Protections
(Applies only to Separate child health programs)

Section 457.1100 - Basis, Scope and Applicability

- This provision indicates that this subpart interprets and implements Sections 2101(a), 2102 (a) and (b), and 2103 of the Act, and sets forth minimum standards for privacy protection and for procedures for review of matters relating to eligibility, enrollment, and health services. The provision also establishes that this subpart only applies to a separate child health program.

Section 457.1110 - Privacy Protections

- This provision requires States to ensure that States protect the confidentiality, privacy and abide by disclosure rules (by complying with subpart F of part 431 of this chapter) for individual medical records and any other health and enrollment information maintained with respect to enrollees, identifying particular enrollees (in any form).

  - States must specify and make available to any enrollee requesting it, a list of the purposes for which information is maintained or used; and to whom and for what purposes the information will be disclosed outside the State.
  - Each enrollee may request and receive a copy of records and information pertaining to the enrollee in a timely manner and that an enrollee may request that such records or information be supplemented or corrected.

Section 457.1120 - State Plan Requirement: Description of Review Process

- This provision requires that the State plan must include a description of the State s review process.

Section 457.1130 - Matters Subject to Review

- This provision sets forth that there are two matters subject to review: eligibility or enrollment matters and health services matters.

  - For eligibility and enrollment matters, a State must ensure that an applicant or enrollee has an opportunity for review of a denial of eligibility; failure to make a timely determination of eligibility; or suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

  - For a health services matter, a State must ensure that an enrollee has an opportunity for external review of a delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; or failure to approve, furnish, or provide payment for health services in a timely manner.

  - A decision need not be reviewed if the sole basis for the decision is a State or a Federal policy requiring an automatic action that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

Section 457.1140 - Core Elements of Review

- This provision sets forth the core elements that each State must assure are part of the review process. States have broad flexibility to design their review process as long as:

  - Reviews are conducted by an impartial person or entity;
  - Reviews are timely;
  - Review decisions are provided in writing; and
  - Applicants and enrollees have an opportunity to –
    - represent themselves or have representatives of their choosing in the review process;
    - review their files and other applicable information relevant to the review of the decision in a timely manner;
    - fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process; and
    - have an eligibility review before coverage is suspended or terminated.

Section 457.1150 - Impartial Review

- This provision sets forth that reviews of an eligibility or enrollment matter must be conducted by an individual or entity who has not been directly involved in the matter under review.

- For health services matters, the State must ensure that an enrollee has an opportunity for an independent external review, which must be conducted by the State or a contractor other than the contractor responsible for the matter subject to external review.

Section 457.1160 - Time Frames

- This provision sets forth the time frames within which reviews of an eligibility or enrollment matter and a health services matter must occur.

  - For an eligibility or enrollment matter, we are proposing that a State must complete the review within a reasonable amount of time. In setting time frames, the State must consider the need for expedited review when there is an immediate need for health services.
  - For a health services matter, States must ensure that reviews are completed in accordance with the medical needs of the patient within the following time frames:
    - External review must be completed within 90 days of the date the enrollee requests internal (if available) or external review. The entire review process must be completed within 90 days.
    - The State must provide an expedited time frame of 72 hours in cases where the standard time frame will seriously jeopardize the enrollee's life or health. Where both internal and external review is available, each level of review may not exceed 72 hours. The State may also extend the 72 hour timeframe by up to 14 days at the enrollee's request.

Section 457.1170 - Continuation of Enrollment

- This provision requires a State to ensure the opportunity for review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing, before coverage is suspended or terminated.

Section 457.1180 – Notice

- This provision sets forth that a State must provide enrollees and applicants timely written notice of any determinations required to be subject to review. The notice must include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

Section 457.1190 - Application of Review Procedures when States Offer Premium Assistance for Group Health Plans

- This provision sets forth that a State that has a premium assistance program that does not meet the review requirements must give applicants and enrollees the option to obtain health benefits coverage other than through that group health plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

Related Revisions to Medicaid Regulations - Parts 431, 433, 435 and 436

Section 433.11 - Enhanced FMAP Rate for Children

- This provision makes changes to Part 430 of the regulations necessary to incorporate the policies pertaining to FFP that are explained in the SCHIP financial regulation.

Section 431.636 - Coordination of Medicaid with the State Children s Health Insurance Program

- This provision requires the State Medicaid agency to have procedures in place to facilitate the Medicaid application process for children that have applied for a separate child health program and have been screened as potentially eligible for Medicaid. The procedures must ensure that –
  - The applicant is not required to provide duplicative information or documentation that has already been provided to the separate child health program;
  - Eligibility is determined in a timely manner;
  - The Medicaid agency promptly notifies the separate child health program when a determination of Medicaid eligibility has been made; and
  - The Medicaid agency facilitates enrollment in the separate child health program in the event that the child is not eligible for Medicaid (at initial application and at renewal).

Section 435.229/Section 436.229 - Optional Targeted Low-Income Child

- This provision adds the new optional group of optional targeted low-income children to the existing optional groups. In general, all regular Medicaid rules apply to this group.

Section 435.4/Section 436.3 - Definitions and Use of Terms

- This provision clarifies that children covered by section 1115 demonstrations that had only a limited benefit package are not considered for purposes of the maintenance of effort requirements in the statute. Such children are therefore not excluded from the definition of optional targeted low-income child for purposes of enhanced matching.

Section 435.910 - Use of Social Security Number

- This provision explains that a Medicaid identification number other than a Social Security Number may be given to an individual who, because of well-established religious objections, refuses to obtain a Social Security Number.

Section 435.1001 - FFP for Administration

- This provision states that FFP is available for administrative functions such as Medicaid eligibility determinations and redeterminations, and determining presumptive eligibility for children.

Section 435.1002 - FFP for Services

- This provision makes FFP available for services provided to presumptively eligible children.

Section 435.1101 – Definitions Related to Presumptive Eligibility for Children

- This provision defines terms related to providing presumptive eligibility for children, including *application form, period of presumptive eligibility, presumptive income standard, qualified entity and services.* Specifically the definition of qualified entity has been expanded as a result of the BIPA of 2000 –

  - A *qualified entity* is an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children. This definition includes entities authorized to determine eligibility for Head Start, child care services under the Child Care and Development Block Grant of 1990, WIC, the Stewart B. McKinney Homeless Assistance Act, the U.S. Housing Assistance Act or the Native American Housing Assistance and Self Determination Act; and certain elementary and secondary schools including those operated by the Bureau of Indian Affairs. This term also includes any other entity the State so deems, as approved by the Secretary of HHS.

Section 435.1102 – General Rules Related to Presumptive Eligibility for Children

- This provision provides States with the option of providing presumptive eligibility for children in the same manner, as presumptive eligibility for pregnant women is determined. The provision also allows States to establish reasonable methods of limiting the number of periods of presumptive eligibility, which will be authorized for a child in a given time frame. The provision also requires States provide all services, including EPSDT, to presumptively eligible children.